

# CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

**Kevin Y Riley** - Licensed Clinical Social Worker, CADC III

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last  
 Gender: M \_\_\_ F \_\_\_ Age: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Parents/ Guardians: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Telephone(s): \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work)  
 e-mail: (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 May we leave messages for you?  home phone  work phone  email  other \_\_\_\_\_  No

Parents/ Guardians: 3. \_\_\_\_\_ 4. \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Telephone(s): \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work)  
 e-mail: (1) \_\_\_\_\_ (2) \_\_\_\_\_  
 May we leave messages for you?  home phone  work phone  email  other \_\_\_\_\_  No  
 Others living in the home or siblings outside home

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:
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Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred by: \_\_\_\_\_

	Education	Occupation	Employer
Parent 1			
Parent 2			

	Education	Occupation	Employer
Parent 3			
Parent 4			

Client Name:
<b>PROBLEMS &amp; STRENGTHS</b>
Describe the issues or problem(s) that brought you here today:
When did these problems begin?
What are your child's strengths? What is going well in your child's life?
How is the family functioning?
Current School: _____ How is your child's academic ability & performance?
How is the relationship of parents or care-givers?

What are your goals for this visit?
Is there any other information that may be helpful (for example, issues of diversity, spirituality, or health)?

<b>Check any of the symptoms that your child is having:</b>			
	Depression		Feeling of extreme happiness
	Extreme sadness		School Problems
	Trouble concentrating		Problems getting along with friends or family
	Memory problems		Cold / Flu
	Feeling hopeless		Injuries
	Lack of energy		Chronic Health Conditions
	Feeling tearful		Physical complaints of pain
	Lack of enjoyment of usual activities		Change in sexual interest or function
	Change in eating habits		Disordered Eating
	Change in sleeping habits		Weight changes
	Loss or Grief		Substance Abuse
	Self-esteem problems		Feeling stressed
	Perfectionism		Easily irritated
	Feeling fearful		Problems with anger
	Feeling guilty		Acting violently
	Feeling nervous		Legal Problems
	Obsessions or compulsions		Thoughts of hurting self or others
	Sudden feelings of panic		Thoughts of killing self or others

<b>MEDICAL INFORMATION</b>	
Has your child seen a doctor within the last year? <span style="float: right;">Yes [ <input type="checkbox"/> ]      No [ <input type="checkbox"/> ]</span>	
Why did they see a doctor?	
Who is your doctor?	Phone:
Is your child taking any medications, prescription or over-the-counter? <span style="float: right;">Yes [ <input type="checkbox"/> ]      No [ <input type="checkbox"/> ]</span>	
Medications	Dosages
1.	
2.	
3.	
4.	
Does your child have allergies to anything? <span style="float: right;">Yes [ <input type="checkbox"/> ]      No [ <input type="checkbox"/> ]</span>	
Please describe allergy problems that they have:	

HAS YOUR CHILD OR FAMILY EVER BEEN IN COUNSELING BEFORE? Yes [ <input type="checkbox"/> ] No [ <input type="checkbox"/> ]
If yes, please describe counseling below. Start with the most recent time first.

A. Date(s):	
Name of provider:	
Explain what happened:	

B. Date(s):	
Name of provider:	
Explain what happened:	

C. Date(s):	
Name of provider:	
Explain what happened:	

<b>SUBSTANCE USE HISTORY</b>			
Does your child use/ have they used tobacco (any form)?	Current [ ]	Past [ ]	No [ ]
Does your child use/ have they used alcohol?	Current [ ]	Past [ ]	No [ ]
Does your child use/ have they used caffeine (any form, including cola drinks)?	Current [ ]	Past [ ]	No [ ]
Does your child use/ have they used other mind-altering substances (drugs)? Please Describe:	Current [ ]	Past [ ]	No [ ]

IF THERE IS OTHER INFORMATION YOU THINK IS IMPORTANT, PLEASE WRITE BELOW OR ON THE BACK